*Booklet 4*

# Washington Dental Service

Washington Dental Service

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

**Call 206-684-1556 for alternate formats.**

# Table of Contents: Washington Dental Service Plan

# Overview

### ► Highlights of Coverage under Washington Dental Service (WDS)

Here are a few highlights of your dental benefits:
- You can use any dentist you wish (most dentists in Washington participate in the WDS plan)
- The plan pays benefits if you see a participating or non-participating dentist, but the benefits are generally higher (your out-of-pocket expenses are less) if you see a participating dentist
- Participating dentists file claims for you automatically.

### ► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

# Cost

When you receive dental care, you pay:
- An annual deductible for applicable services (the annual deductible does not apply to diagnostic and preventive services, orthodontic services or accidental injuries)
- Coinsurance amounts not covered by the plan
- Amounts in excess of the allowable amounts (as determined by WDS) if you see a non-participating dentist
- Expenses for services or supplies not covered by the plan.

See "How the Plan Works" in this booklet (next page) for more information; also see the latest new hire guides and open enrollment materials for details about monthly premiums you must pay (if any) for the coverage.

# How the Plan Works

### ► Summary Table

The table on the following page summarizes covered services and supplies under this plan and identifies related deductibles, coinsurance and maximums (see "Covered Expenses under WDS" and "Expenses Not Covered" in this booklet for more details).

| Washington Dental Service | |
|---|---|
| **Annual deductible** (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries) | $25/person, $75/family |
| **Annual maximum benefit** (doesn't apply to orthodontic or TMJ services) | $2,000/person |
| **Covered Expenses** | **Plan Pays** |
| **Diagnostic and preventive services**<br>• Exam and cleaning twice a calendar year<br>• Periodontal cleaning and maintenance up to 4 times in a calendar year (under certain oral health conditions)<br>• Complete x-rays every 3 years<br>• Supplementary bitewing x-rays twice a calendar year | 70% - 100% based on patient's incentive level (deductible doesn't apply) |
| **Basic services**<br>• Crowns (stainless steel)<br>• Extractions<br>• Fillings<br>• Periodontics<br>• Root canals | 70% - 100% based on patient's incentive level |
| **Major services – restorative**<br>• Crowns<br>• Onlays | 70% - 85% based on patient's incentive level |
| **Major services – prosthodontics**<br>• Dentures<br>• Fixed bridges<br>• Implants | 70% (incentive levels do not apply) |
| **Orthodontic services for adults and children** | 50% up to a $2,500 lifetime maximum (deductible and incentive levels do not apply; benefit doesn't apply to the annual maximum benefit)<br>Not more than $1,250 will be paid during the initial stage of treatment; the remaining plan benefit is paid 7 months after the initial stage if the covered participant still meets eligibility requirements described in the Important Facts booklet |
| **Night (occlusal) guard** | 50% (incentive levels do not apply; your medical plan may provide additional coverage — see the appropriate booklet) |
| **Temporomandibular joint (TMJ) disorders** | 50% up to a $500 lifetime maximum for non-surgical treatment and appliances (incentive levels do not apply and this benefit doesn't apply to the annual maximum benefit; your medical plan may provide additional coverage — see the appropriate booklet) |
| **Accidental injury** | 100% for covered expenses incurred within 180 days of accident (deductible doesn't apply) |

## ► Participating and Non-Participating Dentists

You may select any licensed dentist. Tell your dentist you're covered by a program administered by WDS for King County. The group number is 152. You must provide either your Social Security number or unique identifier (if assigned one by WDS).

If you go to a participating dentist, the dentist submits claim forms to WDS and receives payment directly. You are responsible for any remaining balance. If you see a non-participating dentist, it's your responsibility to see that the claim form is submitted (see "Filing a Claim" in this booklet).

## ► Benefit Maximums

The maximum the plan pays each calendar year for most covered expenses is $2,000 per person. The lifetime maximum payable by WDS for orthodontic treatment is $2,500 per person. The lifetime maximum payable by WDS for TMJ treatment is $500 per person.

Charges for dental procedures requiring multiple treatment dates (such as crowns or bridgework) are considered incurred on the date the service is complete.

## ► Incentive Program

WDS increases your payment levels through an incentive program as long as you see your dentist each year:

- For diagnostic and preventive services as well as basic services, the payment level starts at 70% and increases 10% in January of each year until you reach 100%
- For major restorative services the payment level increases from 70% to 80%, then to 85%

If you do not see the dentist during the calendar year, your payment level is reduced to the next lower payment level, but never below 70%. The reduction is from the level under which your last claim was paid. For example, if you saw your dentist in 2001 and your payment level was 80%, but you did not see your dentist in 2002, your payment level in 2003 is reduced from 80% to 70%.

Major prosthodontic services, orthodontia, TMJ treatment and night (occlusal) guards are not under the incentive program.

The following table summarizes how the incentive program works.

| If you receive these services ... | The plan pays ... |
|---|---|
| Diagnostic and preventive services<br>Basic services | 70% first year<br>80% second year<br>90% third year<br>100% fourth year and each year thereafter |
| Major services – restorative | 70% first year<br>80% second year<br>85% third year and each year thereafter |

Example 1. This is Rachel's second year of plan participation. This year, Rachel visits her participating dentist for her annual cleaning. Since she visited the dentist last year, her coinsurance level for this year increased from 70% to 80%. She doesn't need to meet the annual deductible before the plan pays for covered diagnostic and preventive services. Here's how much Rachel pays:

| Total Expense | Plan Pays | Rachel Pays |
|---|---|---|
| $ 45 Exam | $ 36 (80% of $45) | $ 9 (20% of $45)<br>+ 0 Deductible<br>$ 9 |

The annual deductible does not apply to the type of service Rachel received (preventive).

Example 2. Jim has participated in this plan for three years, but hasn't been to the dentist during any of those years. This year Jim needs a root canal. Here's how much Jim pays:

| Total Expense | Plan Pays | Jim Pays |
|---|---|---|
| $ 600 Root canal<br>- 25 Deductible<br>$ 575 | $ 402.50 (70% of $575) | $ 172.50 (30% of $575)<br>+ 25.00 Deductible<br>$ 197.50 |

The annual deductible does apply to the type of service Jim received (basic). His deductible for the calendar year is met on this claim.

### ► Predetermination of Benefits

If you think your dental care will exceed $200 and for all orthodontic and TMJ services, ask your dentist to submit a standard WDS claim form for predetermination. This way you'll learn in advance exactly what procedures are covered, the amount WDS will pay toward the treatment and the amount you'll need to pay. (WDS conducts professional clinical reviews of basic and major services. If professional dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by your dentist, WDS limits benefits to the less costly alternative, unless otherwise noted or restricted in the next section, "Covered Expenses under WDS." You are responsible for any treatment costs exceeding the allowable amounts paid by WDS.)

Predetermination requires notification or approval before you receive dental care. WDS will provide notice of the claim decision within 15 days after receiving your claim form. If a predetermination is filed improperly, WDS will provide notice of the improper filing and how to correct it within five days after receiving the predetermination filing. If more information is required, WDS will notify you of what is needed within 15 days after receiving the claim.

WDS may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you have 45 days to submit this information and WDS will make a determination within 15 days. If the information isn't submitted within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan it's based on, and describe the claim appeal procedures (see "Appealing a Denied Claim" in this booklet for further details).

For an emergency, immediate treatment is allowed without predetermination and the claim is evaluated after treatment.

## Covered Expenses under WDS

This section describes covered expenses and any related limits. To be covered, expenses must be medically necessary for treatment, diagnosis or prevention of a dental condition.

If professional dental standards indicate the condition can be treated by a less costly alternative to the service proposed by your dentist, in some cases this plan will limit benefits to the less costly alternative (WDS determines on a case-by-case basis). You are responsible for any treatment costs exceeding the allowable amounts paid by WDS (see "Predetermination of Benefits" above).

### ► Diagnostic and Preventive Services

- WDS-approved caries (decay) susceptibility tests
- Exam – emergency
- Exam – routine, twice per calendar year
- Exam by a specialist in an American Dental Association-recognized specialty

- Fissure sealants for children through age 14 or younger; if eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist; payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface (the application of fissure sealants is a covered benefit only once in three years per tooth)
- Periodontal cleaning and maintenance or prophylaxis (cleaning), up to four times a calendar year (under certain oral health conditions)
- Preventive therapies, such as fluoridated varnishes, approved by WDS under certain conditions of oral health (when performed as the suggested regimen for that therapy); children through age 18 are eligible for either topical application of fluoride (as described below) or preventive therapies, but not both
- Prophylaxis (cleaning), twice per calendar year
- Space maintainers for the eruption of permanent teeth
- Topical application of fluoride twice per calendar year for children age 18 or younger
- X-rays (complete series or panorex), once in three years; supplementary bitewing x-rays, twice per calendar year.

## ► Basic Services

- Amalgam, filled resin or composite fillings to treat decay or fracture resulting in significant tooth loss
- General anesthesia/intravenous sedation:
  - If administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines in conjunction with certain covered surgical procedures as determined by WDS
  - When medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures
- Localized delivery of chemotherapeutic agents approved by WDS under certain conditions of oral health when performed as the suggested regimen for that therapy; must be preceded by scaling and root planing at a minimum of six weeks and a maximum of six months or the patient must have been in active supportive periodontal therapy before the treatment
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures
- Pulp exposure treatment, pulpotomy and apicoectomy
- Pulpal and root canal treatment (root canal treatment on the same tooth is covered once in two years)
- Removal of teeth and surgical extractions
- Restorations on the same surface(s) of the same tooth, once in two years (if a filled resin or composite filling is placed in a posterior tooth, the plan pays benefits as if it were an amalgam
- Stainless steel crowns, once in two years
- Surgical and non-surgical procedures to treat the tissues supporting the teeth, including exams, periodontal maintenance, periodontal scaling/root planing (once in 12 months), periodontal surgery and soft tissue grafts (once in three years per site); periodontal surgery must be preceded by scaling and root planing at a minimum of six weeks and a maximum of six months or the patient must have been in active supportive periodontal therapy before the treatment
- Treatment of pathological conditions and traumatic facial injuries.

If teeth are restored with crowns, inlays or onlays, refer to the following sections.

## ► Major Services – Restorative

- Crowns (on the same teeth, once in five years)
- Onlays (on the same teeth, once in five years).

Gold, porcelain, WDS-approved gold substitute castings (except processed resin) or combinations of these may be used in major restorative services.

Crowns and onlays are covered only to treat decay or fracture resulting in significant tooth loss (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin.

### ► Major Services – Prosthodontics

Dentures, fixed bridges, inlays if used as an abutment for a fixed bridge (on the same teeth, once in five years), removable partial dentures and adjustment or repair of an existing prosthesis unless limited by:

- Denture adjustments and relines done more than six months after the initial placement. These are covered, except as noted under temporary/interim dentures below. Subsequent relines or rebases, but not both, will be covered once in 12 months.
- Dentures (temporary/interim). If you receive an interim partial or full denture, the plan pays as if you received a reline. After placement of the permanent prosthesis, an initial reline is covered after six months.
- Dentures (partial). If a more elaborate or precision device is used, the plan pays as if you received a cast chrome and acrylic partial denture.
- Full, immediate and overdentures. For personalized restorations or specialized treatment, the plan pays as if you received a full, immediate or overdenture.
- Replacement of an existing prosthetic device. This is covered once in five years and only then if it's unserviceable and cannot be made serviceable.
- Replacement of implants and superstructures, covered only after five years have elapsed from any prior implant.
- Root canal treatment performed in conjunction with overdentures. This is limited to two teeth per arch.
- Surgical placement or removal of implants or attachments to implants.

### ► Orthodontic Services

This plan covers orthodontic care for adults and children. All orthodontic treatment must be authorized by WDS before treatment begins (see "Predetermination of Benefits" in this booklet).

### ► Other Services

- Night (occlusal) guard once in three years
- Nonsurgical treatment and appliances to treat temporomandibular joint (TMJ) disorders.

### ► Accidental Injury

The plan pays 100% of covered expenses directly resulting from an accidental bodily injury, up to the annual maximum, if for diagnosis and treatment performed/incurred within 180 days after the accident. The accidental bodily injury and treatment must have occurred while the patient was eligible. Payment for accidental injury claims will not exceed the unused maximum. A bodily injury does not include teeth broken or damaged while chewing or biting on foreign objects.

## Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the WDS plan does not cover:

### ► Diagnostic and Preventive Services

- Cleaning of prosthetic appliances
- Consultations or elective second opinions
- Plaque control program (oral hygiene instruction, dietary instruction or home fluoride kits)
- Replacement of a space maintainer previously paid for by WDS
- Study models.

### ► Basic Services

- Bleaching of teeth
- Crowns as part of periodontal therapy
- Gingival curettage
- Iliac crest or rib grafts to alveolar ridges
- Localized delivery of chemotherapeutic agents when used to maintain non-covered dental procedures or implants
- Occlusal splints
- Overhang removal, recontouring or polishing of restoration
- Periodontal appliances
- Periodontal splinting or crown and bridgework in conjunction with periodontal splinting
- Restorations necessary to correct vertical dimension or to modify shape of teeth or occlusion
- Ridge extension for insertion of dentures
- Tooth transplants.

### ► Major Services

- Cleaning of prosthetic appliances
- Crowns or copings in conjunction with overdentures
- Crowns or onlays placed because of weakened cusps or existing large restorations without overt disease
- Crowns used as an abutment to a partial denture for recontouring, repositioning or increasing retention (unless the tooth is decayed to the extent that a crown would be needed whether or not a partial denture is required)
- Crowns used to repair micro-fractures of tooth when it displays no symptoms or existing restorations with defective margins when no disease exists
- Duplicate dentures
- Personalized dentures.

## What Happens If

### ► If You Need Emergency Care

If you need emergency dental care, you may see either a participating or non-participating dentist. Your benefits depend on the type of services you receive (see "Summary Table" and "Incentive Program" in this booklet for benefit levels).

### ► If You Need Care While Traveling

If you receive treatment from a dentist outside Washington State, you pay the dentist in full, then submit a claim form as described in "Filing a Claim" in this booklet. Payment is based on the dentist's charge, or the amount that would have been payable if treatment had been provided by a participating WDS dentist, whichever is less.

### ► If Your Family Member Lives Away from Home

Family members who live away from home either temporarily or permanently may see a non-participating dentist and still receive benefits from this plan. Your family member must file a claim (see "Filing a Claim" in this booklet).

## Coordination of Benefits between Plans

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a family member both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other.

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.
  - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

# Filing a Claim

### ► What to Do

If you receive care from a participating provider, the provider submits claims for you. If you receive services from a non-participating provider, you pay the provider in full, and it's your responsibility to submit a claim form to WDS or have the provider submit one for you. Claim forms are available from WDS (see Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or CDT-4 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number 152.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

### ► How the Claim is Reviewed

WDS will review your claim and notify you or your provider in writing within the following timeframes:

- Within 72 hours for urgent claims. Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You will be notified of the claim review decision by phone with a written notice to follow.
- Within 15 days for pre-service claims (within 30 days if an extension is filed). Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- Within 24 hours for concurrent claims. Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- Within 30 days for post-service claims (within 60 days if an extension is filed). Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the timeframes listed above.

### ► If the Claim is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

### ► If the Claim is Denied

If the claim is denied, you are notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that WDS reviewed in making the determination.

## Appealing Denied Claims

### ► Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, WDS notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling WDS and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal (see the Resource Directory booklet for contact information).

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

WDS will review the written appeal and notify you or your representative of their decision within these timeframes:

- Within 72 hours for urgent appeals
- Within 15 days for pre-service appeals
- Within 30 days for post-service appeals

- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies the plan provisions and their discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you are notified in writing of reasons for the denial.

If you disagree with the appeal decision, you may submit the matter to a mutually agreed upon nonbinding mediator. If you and WDS cannot agree upon a mediator within 15 days, WDS will submit the matter to the American Arbitration Association or Judicial Arbitration and Mediation Service.

WDS has sole discretionary authority to determine benefit payment under the plans; their decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within six years after the event the claim is based on or you forfeit your right to legal action.

### ► Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of the section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- Within 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- Within 14 days for pre-service appeals (within 30 days if an extension is filed)
- Within 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the

plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

## Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

## Payment of Dental Benefits

The dental benefits offered by this plan are funded by King County, making this a "self-funded" plan. Though Washington Dental Service is responsible for the payment of claims, King County is financially responsible for the cost of those claims.